Washington State Health Care Authority
Public Employees Benefits Board

2013 Employee Enrollment/Change for Medical Only Groups

- **List eligible family members you wish to cover or remove from coverage. This form replaces all *Employee Enrollment/ Change* forms previously submitted.**
- **Type or print clearly in black ink.** Inaccurate, incomplete, or illegible information may delay coverage.

Subscriber's last name	First name	Middle initial	Social security number

Are you making changes to an existing account?

❑ **Yes** **If yes, what changes?** *(Check all that apply in the sections below.)*

❑ **No** *If no, go to Section 1 on page 2.*

Changes you can make anytime

Give date of event/change _____

❑ Name change ❑ Address change

❑ Remove dependent(s) from coverage due to loss of eligibility (divorce, dissolution of domestic partnership, death, or other loss of eligibility for PEBB benefits). **You must submit this form no later than 60 days after the event.** If applicable, provide dependent's new address:

_____

Additional changes you can make during annual open enrollment

All changes become effective January 1 of the following year.

Check the box(es) next to the change requested.

❑ Add dependent(s) ❑ Enroll after waiving medical coverage ❑ Change medical plan

❑ Remove dependent(s) ❑ Waive medical coverage due to other comprehensive group medical coverage

Additional changes you can make if an event creates a special open enrollment

The PEBB Program allows changes outside of an annual open enrollment when an event creates a special open enrollment. Internal Revenue Code requires the change must be on account of and correspond with an event that affects eligibility for coverage. You may be required to provide proof of the event that created the special open enrollment. **You must submit this form no later than 60 days after the event.** However, if adding a newborn or newly adopted child, and adding the child increases your premium, you must submit this form no later than 12 months after the birth or adoption.

Check the box(es) next to the change(s) you are requesting. You must have experienced a corresponding event as shown on the next page. See the numbers beside each change to verify your requested change may be allowed.

❑ **Add dependent(s)** (allowable under events 1, 2, 3, 4, 5, 6, 7, 9, 10)

❑ **Enroll after waiving medical coverage** (allowable under events 1, 2, 3, 4, 5, 6, 7, 9, 10)

❑ **Change medical plan** (allowable under events 1, 2, 3, 4, 5, 8, 9, 10, 11, 12, 13)

❑ **Remove dependent(s)** (allowable under events 1, 5, 6, 9, 10)

❑ **Waive medical coverage due to other comprehensive group medical coverage** (allowable under events 1, 5, 6, 9, 10)

Give date of event_____

(this section continued on next page)

Agency name	Agency/subagency	Insurance effective date	Hire date

Additional changes you can make if an event creates a special open enrollment

(continued from previous page)

Check the box(es) next to the corresponding event(s). The event number must be listed next to the requested change(s) on the previous page.

❑ 1. Marriage, registering a domestic partner, birth, adoption, or assuming a legal obligation for total or partial support in anticipation of adoption. *Also complete a* Declaration of Tax Status *form if adding a domestic partner and/or his or her eligible children. Form available at* **www.pebb.hca.wa.gov**.

❑ 2. Child becoming eligible as an extended dependent through legal custody or legal guardianship. *Also complete an* Extended Dependent Certification *form. Form available at* **www.pebb.hca.wa.gov**.

❑ 3. Child becoming eligible as a dependent with a disability. *Also complete a* Certification of Dependent With a Disability *form. Form available at* **www.pebb.hca.wa.gov**.

❑ 4. Employee or dependent losing other coverage under a group health plan or through health insurance, as defined by the Health Insurance Portability and Accountability Act (HIPAA).

❑ 5. Employee or dependent having a change in employment status that affects the employee's or dependent's eligibility for the employer contribution toward group health coverage.

❑ 6. Employee or dependent having a change in enrollment under another employer plan during its annual open enrollment that does not align with the PEBB Program's annual open enrollment.

❑ 7. Employee's dependent moving from outside the United States to live within the United States.

❑ 8. Employee or dependent having a change in residence that affects medical plan availability.

❑ 9. A court order or National Medical Support Notice requires the employee or any other individual to provide insurance coverage for an eligible dependent of the employee.

❑ 10. Employee or a dependent becoming eligible or losing eligibility for premium assistance through Medicaid or a state Children's Health Insurance Program (CHIP).

❑ 11. Employee or dependent becoming entitled to Medicare, or enrolling in or disenrolling from a Medicare Part D plan.

❑ 12. Employee or dependent's current health plan becoming unavailable because the employee or dependent is no longer eligible for a health savings account (HSA).

❑ 13. Employee or dependent experiencing a disruption of care that could function as a reduction in benefits for the employee or his or her dependent for a specific condition or ongoing course of treatment (requires PEBB approval).

Are you or any eligible dependents enrolled in PEBB coverage under another account? ❑ **Yes** ❑ **No**

Section 1: Subscriber Information

Social security number	Last name	First name	Middle initial	Sex ❑ M ❑ F

Street address	Apt./unit number	City	State	ZIP Code
Mailing address (if different from above)	**Apt./unit number**	**City**	**State**	**ZIP Code**

County of residence	Date of birth (mm/dd/yyyy)	Work phone number ( )	Home phone number ( )

Medical Coverage ❑ Cover ❑ Waive: effective date _____

If waiving, see Section 5. **Note:** If you waive coverage, you must have other comprehensive group medical coverage. You cannot enroll your eligible dependents in medical.

(continued)

Subscriber's last name	First name	Middle initial	Social security number

Section 2: Spouse or State-Registered Domestic Partner

List an eligible spouse or state-registered domestic partner you wish to cover or remove from coverage. Family members cannot be enrolled in two PEBB medical or dental accounts at the same time. ***If adding a spouse or partner, you must provide proof of eligibility within PEBB's enrollment timelines or the spouse or partner will not be enrolled.*** *A list of documents we will accept to show proof of eligibility is available at* **www.pebb.hca.wa.gov** *under* Dependent Verification.

Relationship to subscriber
(If adding a state-registered domestic partner, please attach a completed *Declaration of Tax Status* form.)

❑ Spouse: date of marriage _____ ❑ Domestic partner: date registered _____

Social security number	Last name	First name	Middle initial	Sex ❑ M ❑ F

Street address (only if different from subscriber) Apt./unit number	City	State	ZIP Code

Date of birth (mm/dd/yyyy)	**Medical Coverage** ❑ Cover ❑ Remove Reason _____

Section 3: Family Member Information (such as child) *Use additional forms for more members.*

List eligible family members you wish to cover or remove from coverage. Family members cannot be enrolled in two PEBB medical or dental accounts at the same time. ***If adding a family member, you must provide proof of eligibility within PEBB's enrollment timelines or the family member will not be enrolled.*** *If adding a child of your state-registered domestic partner, also attach a* Declaration of Tax Status *form. Also attach appropriate dependent certification form(s) if enrolling a dependent with a disability age 26 or older, or an extended dependent. Forms and a list of acceptable dependent verification documents (to show proof of eligibility) are available at* **www.pebb.hca.wa.gov**.

A

Relationship to subscriber	Disabled? ❑ Yes ❑ No *(Check only if age 26 or older.)*	Sex ❑ M ❑ F	Social security number

Last name	First name	Middle initial	Date of birth (mm/dd/yyyy)

Street address (only if different from subscriber) Apt./unit number	City	State	ZIP Code

Medical Coverage ❑ Cover ❑ Remove Reason _____

B

Relationship to subscriber	Disabled? ❑ Yes ❑ No *(Check only if age 26 or older.)*	Sex ❑ M ❑ F	Social security number

Last name	First name	Middle initial	Date of birth (mm/dd/yyyy)

Street address (only if different from subscriber) Apt./unit number	City	State	ZIP Code

Medical Coverage ❑ Cover ❑ Remove Reason _____

C

Relationship to subscriber	Disabled? ❑ Yes ❑ No *(Check only if age 26 or older.)*	Sex ❑ M ❑ F	Social security number

Last name	First name	Middle initial	Date of birth (mm/dd/yyyy)

Street address (only if different from subscriber) Apt./unit number	City	State	ZIP Code

Medical Coverage ❑ Cover ❑ Remove Reason _____

(continued)

Please sign and date this form on the next page.

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Subscriber's last name	First name	Middle initial	Social security number

Section 4: Medical Plan Selection *Check only one.*

Contact plans for benefits information; their contact information is at the end of this form.

Group Health Cooperative
- ❑ Group Health Classic
- ❑ Group Health Value

Group Health Options Inc.
- ❑ Group Health Consumer-Directed Health Plan

Kaiser Foundation Health Plan of the Northwest
- ❑ Kaiser Permanente Classic
- ❑ Kaiser Permanente Consumer-Directed Health Plan

Uniform Medical Plan, administered by Regence BlueShield
- ❑ UMP Classic
- ❑ UMP Consumer-Directed Health Plan

Section 5: Signature *Required*

By signing this form, I declare that the information I have provided is true, complete, and correct. If it isn't, or if I do not update this information within the timelines in PEBB rules, to the extent permitted by federal and state law, I must repay any claims paid by my health plan or premiums paid on my behalf. My family members and I may also lose PEBB benefits as of the last day of the month we were eligible. To the extent permitted by law, PEBB or my employer may retroactively terminate coverage for me and my dependents if I intentionally misrepresent eligibility, or do not fully pay premiums when due. In addition, I understand that knowingly providing false, incomplete, or misleading information to an insurance company for the purpose of defrauding the company is a crime, and can result in imprisonment, fines, denial of PEBB benefits, and loss of my job.

If adding a domestic partner to my account, I declare that my partner and I have registered through the Washington Secretary of State's Office or another state.

Enrollment is not complete until verification of the family member's eligibility is successful. I understand that if I'm applying to add a dependent to my PEBB coverage, I must provide copies of documents that verify the dependent's eligibility within PEBB's enrollment timelines or the dependent will not be enrolled.

If I waive medical, I understand I can enroll during the annual open enrollment period or within **60 days** of a special open enrollment event as defined in PEBB rules. If I waive medical for myself, I cannot enroll my eligible family members in medical.

I allow my employer to deduct money from my earnings to pay for the insurance coverage I requested.

If I am enrolling in a consumer-directed health plan with a health savings account (HSA), I must meet HSA eligibility conditions. I understand that my employer will contribute to an HSA on my behalf based on the information I have provided, and that there are limits to these contributions and my HSA contributions (if any) under federal tax law.

This form replaces all *Employee Enrollment/Change* forms previously submitted.

HCA's Privacy Notice: We will keep your information private as allowed by law. To receive our Privacy Notice, call 360-725-0442 or go to **www.pebb.hca.wa.gov.**

Subscriber's signature _____ **Date** _____

Please sign and date this form.
Return completed form and documentation to your personnel, payroll, or benefits office.

2013 PEBB MEDICAL CONTRACTORS

Group Health Cooperative, 320 Westlake Ave. N, Suite 100, Seattle, WA 98109-5233
1-888-901-4636 or TTY 1-800-833-6388

Group Health Options Inc., 320 Westlake Ave. N, Suite 100, Seattle, WA 98109-5233
1-888-901-4636 or TTY 1-800-833-6388

Kaiser Foundation Health Plan of the Northwest, 500 NE Multnomah St., Suite 100, Portland, OR 97232-2099
1-800-813-2000 or TTY 1-800-735-2900

Uniform Medical Plan, administered by Regence BlueShield, P.O. Box 2998, Tacoma, WA 98401-2998
1-888-849-3681 or TTY 711